GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation &
Licensing Administration

SENT VIA FACSIMILE & MAILED

March 4, 2008

Mr. Marshall Gahagan
Administrator
Marjul Homes, Inc.
160 Bryant Street, NW
Washington, DC 20001

RE: 6634 Eastern Ave., NE

Dear Mr. Gahagan:

You will find enclosed Statement of Deficiencies reports for federal certification. The reports enumerate deficiencies found as a result of an incident investigation completed on January 22, 2008. You are required to respond to each deficiency. Although a reasonable period of time may be allowed for actual correction of these deficiencies, it is imperative that your plan, with specific date for anticipated completion, be signed, dated and returned to this office prior to **March 14, 2008**. Since these reports are subject to public disclosure, it is necessary that the responses be indicated on the forms (and not on an attachment, except if submitting a copy of a policy change). NOTE: "Corrected" is not an accepted reply. An acceptable plan must also include the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented.

PLEASE NOTE: Failure to submit acceptable plans, within the specified time frame, MAY RESULT in the loss of Medicaid reimbursement.

If you have any questions or concerns regarding the above, please contact Ms. Sheila Pannell, Supervisor of the Intermediate Care Facility Division on (202) 442-5888.

Sincerely,

Patricia W. VanBuren
Program Manager

Enclosure

cc: Department on Disability Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	C 01/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The Department of Health, Health Regulations and Licensing Administration (HRLA) was notified of an allegation of abuse via fax January 14, 2008 and via telephone on January 15, 2008. It was reported that client #1 alleged that she was locked in a closet by a direct care staff. This investigation was initiated on January 16, 2008 to assess the effectiveness of the facility's to ensure that clients were protected from abuse. The investigation was completed on January 22, 2008 and failed to substantiate abuse; however, the investigation determined noncompliance of standard-level regulations.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on the review of the incident management system policy, client #1 ' s behavioral support plan (BSP) and behavioral documentation, the governing body failed to ensure that it exercised the governing The findings include: A review of the Incident Management System procedures dated July 2007 was conducted on January 16, 2008 at 4:20 PM. An investigation regarding the January 12, 2008 incident concluded that the facility ' s direct care staff followed the sequence of notifications once the incident had been alleged by client #1. An investigation was initiated. It could not be determined that these procedures had been implemented consistently as evidenced by the	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 following: Client #1 ' s behavioral documentation for the targeted behavior of " falsified allegations " revealed that the client made past allegations that had not been investigated as directed by her behavioral support plan. The BSP procedures regarding false allegations detailed that " when client #1 reports something, she should be asked if the information is true " . " If (Client #1) insisted that the allegation was true especially in instances of alleged physical abuse, an investigation is required. " The behavior data collection revealed the following documentation: 9/10/07 - Client #1 alleged that she had been choked and the staff told her she could stay up if she wanted to. The intervention was noted to be " staff asked her who choked her and when she couldn ' t answer " . 9/15/07 - Client #1 stated that staff pulled her hair. The intervention section noted " staff asked her who and when and she could not answer " . The documentation was unclear to determine if client #1 had denied all of the allegations that were documented. There were no other investigations provided. It could not be determined that the governing body had ensured that measures had been established effectively evaluate the facility ' s implementation and adherence to the incident management policies and procedures.	W 104		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	W 149		

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W 149	Continued From page 2 This STANDARD is not met as evidenced by: Based on the review of the incident management system policy, client #1 ' s behavioral support plan (BSP) and behavioral documentation, the facility failed to ensure the implementation of the incident management system and failed to consistently conduct investigations accordingly. The findings include: During the investigation, the facility ' s client protection system was review. A review of the Incident Management System procedures dated July 2007 was conducted on January 16, 2008 at 4:20 PM. An investigation regarding the January 12, 2008 incident concluded that the facility ' s direct care staff followed the sequence of notifications once the incident had been conveyed by the client #1 and an internal investigation was initiated. It could not be determined that the facility had implemented their policy procedures regarding investigations consistently. Client #1 ' s behavioral documentation on " falsified allegations " revealed that the client had made allegations that had not been investigated as directed by her behavioral support plan. For Example: 9/10/07 - Client #1 claimed that she had been choked and the staff told her she could stay up if she wanted to. The intervention was noted to be " staff asked her who choked her and when she couldn ' t answer " . 9/15/07 - Client #1 stated that staff pulled her hair. The intervention section noted " staff asked her who and when and she could not answer " . Client #1 ' s BSP procedures regarding false allegations detailed that " when client #1 reports something, she should be asked if the information is true " . " If (Client #1) insisted that the allegation was true especially in instances of alleged physical abuse, an investigation is	W 149		

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W 149	Continued From page 3 required. " There was no consistently documented evidence that client #1 had denied all of the allegations that had been documented. There were no investigations provided for past documented " episodes " .	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on the review of the submitted investigations and client #1 ' s behavioral support plan and documentation, the facility failed to investigate allegations of abuse made by one of three clients in the facility. The findings include: A review of the Incident Management System procedures dated July 2007 was conducted on January 16, 2008 at 4:20 PM. The Incident Management System Policy and Procedures indicated that all allegations of " abuse " would be investigated. Client #1 ' s targeted behaviors included episodes of making false allegations against staff and clients. The BSP procedures regarding false allegations detailed that " when client #1 reports something she should be asked if the information is true " . " If client #1 insisted that the allegation was true especially in instances of alleged physical abuse, an investigation is required. " Client #1 ' s behavioral data collection documentation on " falsified allegations " revealed that the client had made allegations that had not been investigated as directed by her behavioral support plan and subsequently the	W 154		

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W 154	Continued From page 4 incident management system procedures. For Example: 9/10/07 - Client #1 claimed that she had been choked and the staff told her she could stay up if she wanted to. The intervention was noted to be " staff asked her who choked her and when she couldn ' t answer " . 9/15/07 - Client #1 stated that staff pulled her hair. The intervention section noted " staff asked her who and when and she could not answer " . There was no consistently documented evidence that client #1 had denied all of the allegations that were documented and there was no investigation to determine the client ' s safety.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview with the Day Program Case Manager and review of the behavioral support plan, the Qualified Mental Retardation Professional (QMRP), failed to ensure coordination of client #1's BSP between the facility and the day program. The finding includes: It was discovered through interview with client #1's day program case manager that the day program had not included " false allegations " in client #1's behavioral support plan. The case manager stated that this behavior had not been observed at the day program.	W 159		

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W 159	Continued From page 5 The QMRP failed to integrate the all behaviors targeted in the facility into the BSP at the day program. (The QMRP was not available during the on-site visits)	W 159		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on the review of the incident management system policy and client #1's behavioral support plan and documentation, the Human Rights Committee failed to ensure that client #1's behavioral support plan (BSP) supported the protection of the client's rights to be free from harm and the potential of harm. The findings include: During an investigation at the facility, a review of the Incident Management System procedures dated July 2007 was conducted on January 16, 2008 at 4:20 PM. Review of the investigation of the January 12, 2008 allegation of abuse indicated that the that the facility implemented their incident management system. However, it could not be determined that the facility consistently implemented their incident managment policies and procedures regarding the following investigations. Client #1's behavioral documentation on " falsified	W 264		

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W 264	Continued From page 6 allegations" revealed that the client had made allegations that had not been investigated as directed by her behavioral support plan. For Example: 9/10/07 - Client #1 claimed that she had been choked and the staff told her she could stay up if she wanted to. The intervention was noted to be "staff asked her who choked her and when she couldn't answer." 9/15/07 - Client #1 stated that staff pulled her hair. The intervention section noted " staff asked her who and when and she could not answer.". The BSP procedures regarding false allegations detailed that "when (client #1) reports something, she should be asked if the information is true". "If (Client #1) insisted that the allegation was true especially in instances of alleged physical abuse, an investigation is required." There was no consistently documented evidence that client #1 had denied all of the allegations that were documented. It could not be determined that the Human Rights Committee had monitored and reviewed client #1's behavioral management plan and documentation to ensure that plan continued to be suitable for protecting the clients in the facility.	W 264		